SURVEY GUIDE

HOME HEALTH AND HOSPICE LICENSURE AND CERTIFICATION

WISCONSIN
DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
Bureau of Quality Assurance
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SURVEY INFORMATION

Entity Name: _____

Entity Type: _____

License #: _____ **Certification #:** _____

Location: _____

Entrance Date: _____ **Exit Date:** _____

SURVEY GUIDE
HOME HEALTH AND HOSPICE LICENSURE AND CERTIFICATION

This survey guide is a general reference for informational purposes. In the event of any conflict between information provided in this guide and the state and federal legal requirements for home health agencies and hospice agencies, please rely on the applicable legal requirements.

I. INTRODUCTION

The Bureau of Quality Assurance is responsible for conducting unannounced surveys in home health agencies and hospice agencies in Wisconsin to ensure that state licensure and federal Medicare certification requirements are met. The following information has been prepared to serve as a guide to the survey process for licensure and federal certification of home health agencies and hospices.

II. OVERVIEW OF THE SURVEY PROCESS

The purpose of the survey is to determine whether the entity meets applicable state laws, administrative codes, and federal regulations. If an applicant is requesting licensure as a freestanding **hospice**, the Bureau will determine if it complies with the physical environment requirements of Chapter HFS 131, Subchapter IV of the Wisconsin Administrative Code. Surveys are conducted by nursing consultants and engineer/architect surveyors employed by the Wisconsin Division of Disability and Elder Services (DDES), Bureau of Quality Assurance**.**

A. Off-Site Survey Preparation

The surveyor reviews the Bureau's historical file of the entity, profiles, and other applicable information, e.g., waiver/variance reports, OASIS data management and outcome reports.

The scope of the survey may be increased if the entity has had any of the following:

- Repeat violations from last onsite survey;
- Significant complaints, whether or not substantiated, in the past 12 months; or
- Change in ownership or change in key entity personnel since last survey.

B. Entrance Conference

Upon entering the home health agency or hospice, the surveyor will introduce him/herself and ask to meet the administrator and nursing supervisor. The surveyor will request a working area.

The surveyor will inform the entity staff about the survey process, request information needed to conduct the survey, set up a schedule for necessary interviews, and begin to select patients for home visits. The surveyor will inform the entity that staff may accompany the surveyor during the survey, discuss the surveyor's observations and supply additional information throughout the survey and exit conference. The entrance conference takes approximately one–half hour.

1. The surveyor will request the following information from a **home health agency**:

    - For a **state licensure-only** survey, the unduplicated number of patients admitted for all services for the past twelve months, regardless of payment source.

    - For a **Medicare** certification survey, the total number of unduplicated admissions requiring skilled services during a recent twelve-month period.

    - List of personnel, with dates of hire (nurse aides [CNAs] or home health aides, personal care workers [PCWs], nurses, therapists, etc.). This should include contracted employees.

    - Identification of the services provided entirely and directly by agency employees.

    - Copies of the plans of care for patients of all planned home visits and record reviews. Copies of the current medication list, therapy plan of care, home health aide assignment, and other information for those patients, as applicable.

    - Home visit schedule for survey days.

    - List of discharges within the previous 30-60 days.

    - Copy of the patient admission packet (service agreement, complaint form, patient/family rights, etc.).

    - As applicable, completion of CMS 1572, HHA Survey and Deficiency Report.

2. The surveyor will request the following from a **hospice** agency:

    - A current unduplicated patient census number for the past twelve months, including all payment sources;

    - Home visit schedule for survey days;

    - List of personnel and personnel records for all disciplines represented;

    - Copy of the patient admission packet (service agreement, complaint form, patient/family rights, etc.);

    - Copies of the clinical record information (including plans of care, medication sheets, staff assignments, initial evaluations, patient name, diagnosis, date of admission, and services provided) for all planned home visit patients;

    - List of all families currently in the bereavement process and the dates of entry into the program;

    - An interview with the bereavement coordinator, quality assurance staff and volunteer coordinator;

    - A list of contracted services; and

    - As applicable, completion of CMS 417, Hospice Request for Certification in Medicare; and CMS 643, Hospice Survey and Deficiencies Report.

C. Information Gathering

1. Home Visits: The surveyor conducts home visits based on a stratified case-mix sample of all current patients. After receiving the patient's oral or written consent, the surveyor observes entity staff implementing the plan of care in the patient's home.

2. Record Review: The surveyor reviews a stratified case-mix sample of patient clinical records. Patients selected for home visits are included in the sample. A minimum of one bereavement record is included in **hospice** surveys.

3. Personnel Records: The surveyor reviews a sample of agency personnel records of individuals directly employed or under contract. A sample of nurse aide personnel records is reviewed to ensure that the aides meet the Wisconsin Nurse Aide Directory and competency requirements.

4. Branch Office/Multiple Location Visits: Surveyors will visit branch offices or multiple location sites, as appropriate, to ensure that necessary supervision and quality care are being provided. A determination will be made whether the location should be separately licensed and Medicare or Medicaid certified.

5. Partial Extended Surveys: For **home health** agencies, the Bureau conducts a partial extended survey when there are areas of concern outside of the standard survey components, or when components of the standard survey require a more comprehensive review.

6. Extended Surveys:

   - For **home health** agencies**,** the Bureau conducts an extended survey for initial regular licensure determination and when a deficient practice with potential or actual negative outcome is identified during a standard or partial extended survey.

   - Extended surveys will always be conducted for initial regular licensure of a **hospice**.

   - Extended surveys may also be conducted at any time at the discretion of the Bureau of Quality Assurance. An extended survey for a **hospice** will include a review of all requirements of Chapter HFS 131, Wis. Admin. Code, and applicable federal Conditions of Participation. An extended survey for a **home health** agency will include a review of all requirements of Chapter HFS 133, Wis. Admin. Code, and applicable federal Conditions of Participation. The surveyor will contact management staff of the entity prior to initiating an extended survey.

D. Information Analysis and Compliance Decision Making

The surveyor reviews and analyzes all collected information to determine whether the entity has complied with applicable state rules and federal regulations. Analysis and decision-making is an ongoing process throughout the survey. The surveyor maintains ongoing, informal communication with the entity's liaison. Surveyors will provide a daily report of findings.

E. Exit Conference

The exit conference is an informal meeting of the entity and the surveyor at the end of the survey. The surveyor summarizes the preliminary findings, including requirements that have not been met, as well as the facts and examples on which the findings are based. The exit conference also gives the entity the opportunity to discuss the findings and supply additional information. Because of the ongoing dialogue between the surveyor and entity staff during the survey, there should be few instances when the entity is not aware of the surveyor's concerns prior to the exit conference.

The administrator determines which staff, board members, etc., should attend the exit conference. The

entity may have an attorney present, but should give advance notice of this to the surveyor. The exit conference is an informal process, and attorneys do not usually attend. Surveyors have been instructed not to answer any questions from the entity attorney.

A court reporter may not attend the exit conference. If an entity wishes to audio record or video tape the exit conference, it must first obtain permission from the surveyor. An identical, simultaneous recording must be given to the surveyor at the conclusion of the exit conference. Any eavesdropping, or any audio recording or videotaping without the express knowledge and permission of the surveyor, is considered impeding the survey process. This may result in termination of the survey.

III. EXPLANATION OF DEFICIENCY STATEMENTS

The surveyor summarizes the survey findings in a final report. If the surveyor determines that the entity is out of compliance with rules, standards, or regulations; the surveyor will document those findings. The findings serve as a basis for the entity to analyze its deficient practices or system failures and develop plans of correction. Federal survey findings are documented on a CMS 2567 form, Statements of Deficiency. State survey findings are documented on a separate form. Survey findings are served on site or sent via certified mail within ten calendar days following the exit conference.

A. State Rules and Standards of Noncompliance

A violation exists when an entity fails to comply with a state statute or administrative rule. The Department of Health and Family Services promulgates and enforces rules and minimum standards necessary to provide safe and adequate care and treatment, and to protect the health and safety of the patients and employees of the entity. The Department's authority is derived from the following statutes and administrative rules:

Wisconsin Statutes, Section 50.49 – Licensing and Regulation of Home Health Agencies
Wisconsin Statutes, Sections 50.90 to 50.98 – Hospices
Wisconsin Statutes, Section 146.40 – Instructional Programs for Nurse Aides; Reporting Client Abuse
Wisconsin Administrative Code, Chapter HFS 133 – Home Health Agencies
Wisconsin Administrative Code, Chapter HFS 131 – Hospices
Wisconsin Administrative Code, Chapter HFS 12 – Caregiver Background Checks
Wisconsin Administrative Code, Chapter HFS 13 – Reporting and Investigating Caregiver Misconduct
Wisconsin Administrative Code, Chapter HFS 129 – Certification of Programs for Training and Testing Nurse Assistants, Home Health Aides and Hospice Aides

B. Federal Deficiencies

Entities that participate in the federally sponsored Title XVIII (Medicare) and Title XIX (Medicaid) programs are surveyed for compliance with federal regulations. Federal regulations for **home health** agencies are found at 42 CFR 484. Federal regulations for **hospices** are found at 42 CFR 418. Additional federal regulations are also applicable.

A federal deficiency exists when an entity fails to comply with an applicable federal regulation or statute. Beginning with the most severe, the three categories of federal deficiencies are:

1. Noncompliance with Statutory Requirements: A statutory requirement is created by an Act of Congress. Noncompliance with a statutory requirement may subject an entity to termination of its provider agreement with Medicare and Medicaid.

2. Noncompliance with Conditions of Participation: The essential requirements of each of the major divisions of administration and other services are known as Conditions of Participation. A failure to meet a Condition of Participation indicates a breakdown in one of the major health

care systems of the entity. An entity's existing provider agreement may be subject to cancellation or termination if a Condition of Participation is not met.

3. Noncompliance with Standards: A standard is a major subdivision of the requirements in the Conditions of Participation. Noncompliance with a standard may be so serious that it causes noncompliance with the Condition of Participation. Beginning at the Standard level, deficiencies under the federal regulations require an entity to submit a plan of correction to the Department for approval.

IV. PLAN OF CORRECTION

If, after receiving a Statement of Deficiencies, entity staff have questions regarding the survey findings, they may consult informally with the surveyor's supervisor to discuss compliance issues.

A plan to correct violations or deficiencies found by the Bureau should be written on the original Statements of Deficiency, and sent to the attention of the surveyor involved at the appropriate Bureau of Quality Assurance regional office. Additional sheets of paper may be attached if more space to write the plan of correction is needed. An authorized representative of the entity should sign and date the plan of correction.

A. Content

To be considered complete, each plan of correction should include the following:

- What the entity will do to correct the deficient practice and ensure continued compliance in the future;
- How correction will be accomplished and monitored;
- Who will implement the plan and monitor future compliance; and
- When the correction(s) will be completed.

B. Correction of State Violations

An entity that violates state requirements is requested to submit a plan to correct the violations (plan of correction). A **home health** agency that does not participate in the Medicare or Medicaid programs shall submit a plan of correction within ten **working** days following receipt of the Statement of Deficiencies for state violations.

A **hospice** that does not participate in the Medicare or Medicaid programs shall submit a plan of correction within ten **calendar** days of receipt of a Statement of Deficiencies for state violations.

If the entity does not submit an acceptable plan of correction for state violations, the Bureau may impose a plan of correction on the entity. The Bureau may revoke the entity's license for a substantial failure to comply with state statutes or rules.

C. Correction of Federal Deficiencies

A federally certified home health agency or hospice must submit a plan of correction for all federal deficiencies within ten **calendar** days following receipt of a Statement of Deficiencies in order to retain certification in the Medicare or Medicaid programs.

Federal plans of correction that do not meet content standards will be rejected. In such cases, the Bureau will identify why the plan of correction was not acceptable, return the original documents along with the

Plan of Correction Review - Non-Long Term Care Providers (form DDE-2045), and request that an acceptable plan be submitted. The amended plan must be re-signed and re-dated by an authorized representative of the entity. Upon receipt, the Bureau will stamp the amended plan "original" to designate the amended plan as current.

Failure to submit an acceptable plan of correction within ten **calendar** days of receipt of a Statement of Deficiencies for federal requirements may result in termination of the entity's Medicare or Medicaid provider agreement.

D. Time Period for Correction

Correction should be accomplished within 60 calendar days of the exit conference or sooner. Serious deficiencies or violations require a correction date of 30 calendar days or less. If the completion date extends beyond 60 calendar days, the plan of correction must include benchmark dates to specify when correction stages will be completed. The date for correction must be clearly shown in the appropriate column on the Statements of Deficiency and plan of correction form.

An entity that cannot correct a deficiency by the established completion date may request an extension by contacting the surveyor involved. The surveyor and a Health Services Section supervisor will determine whether the correction time is reasonable and will notify the entity of its decision.

E. Verification of Correction

The Bureau of Quality Assurance will verify correction of all state and federal deficiencies after the established completion dates have passed.

F. Failure to Correct Deficiencies

An entity that participates in the Medicare or Medicaid programs is subject to termination of certification when certain criteria are not met, e.g., if conditions of participation are not corrected within 45 calendar days or less from the day the entity receives the Statement of Deficiencies. If an entity is unable to meet federal requirements, the Bureau documents the noncompliance and may initiate termination of federal certification.

Failure to correct a state violation by the date specified in the plan of correction may result in license revocation or conditions being placed on the entity's license.

V. WAIVERS AND VARIANCES

An entity may request that the Department grant a waiver or variance of state rules. The Department may grant the waiver or variance if it finds that the waiver or variance will not adversely affect the health, safety, or welfare of any patient and satisfies certain other criteria. The Department cannot grant a waiver or variance from federal requirements.

A. State Waiver or Variance

1. Definitions:

- **Waiver** means the granting of an exemption from a hospice requirement in chapter HFS 131, Wis. Admin. Code, or a home health agency requirement in Chapter HFS 133, Wis. Admin. Code.

- **Variance** means the granting of an alternate requirement in place of an applicable requirement in Chapter HFS 131 or Chapter HFS 133, Wis. Admin. Code.

2. Requests: Waivers and variances may be requested at any time. They must be made in writing and sent to the Provider Regulation and Quality Improvement Section, Bureau of Quality Assurance, P.O. Box 2969, 1 West Wilson Street, Madison, WI, 53701-2969. The request should explain why the waiver or variance is needed and provide information about the impact of the waiver or variance on patient or resident health, safety, and welfare. A request for a waiver or variance that is part of a proposed plan of correction must also be submitted separately from the plan of correction.

3. Granting or Denying a Waiver or Variance Request: It is the Department's policy to grant or deny each waiver or variance request, in writing, within 60 calendar days of receipt of a completed request. Notice of denials will contain the reason for denial. The terms of a requested variance may be modified upon agreement between the Department and the entity. The Department may impose such conditions on the granting of a waiver or variance that it deems necessary. The Department may limit the duration of any waiver or variance.

4. Waiver or Variance Revocation: The Department may revoke a waiver or variance if:

   - The Department determines that the continuance of the waiver or variance adversely affects the health, safety, or welfare of the patients;

   - The entity fails to comply with a condition imposed on the variance as granted;

   - The entity notifies the Department in writing that it wishes to relinquish the waiver or variance and be subject to the applicable rule; or

   - Revocation of the waiver or variance is required by a change in law.

B. Waivers of Federal Regulations

1. The federal Centers for Medicare and Medicaid Services (CMS), is authorized to grant waivers of federal regulations for Medicare-certified entities. As previously noted, the Wisconsin Department of Health and Family Services is not authorized to grant waivers of federal regulations.

2. CMS may grant a waiver only if an entity can demonstrate that the waiver will not adversely affect the health, safety, or welfare of the patients.

3. Life Safety Code waivers must be requested by letter and entered on the Plan of Correction area of the Statement of Deficiencies form. An entity that requests a waiver of a Life Safety Code on an ongoing basis must resubmit justification for continuance of the waiver annually. All requests for waivers of federal regulations must be submitted in writing and mailed to the Provider Regulation and Quality Improvement Section, Bureau of Quality Assurance, P.O. Box 2969, 1 W. Wilson Street, Madison, WI, 53701-2969. The Bureau of Quality Assurance will forward the request to the Centers for Medicare and Medicaid for final approval or denial.

IV. APPEALS

The following information is for general purposes only. An entity should refer to the applicable legal requirements in effect at the time it receives notice of a Department or federal action that may be subject to appeal.

A. State Appeals

Home health agencies may contest decisions or actions of the Department as specified in section HFS 133.03(8), Wis. Admin. Code. A written request for a hearing, including a copy of the notice of action that is being contested, must be sent to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI, 53707-7875. The request for a hearing must be made within ten calendar days of receipt of the notice of the contested action.

Hospices may contest decisions or actions of the Department as specified in section HFS 131.14(11), Wis. Admin. Code, and sections 50.93(4) and 50.98(4) of the Wisconsin Statutes. A written request for a hearing, including a copy of the notice of action that is being contested, must be sent to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI, 53707-7875. The request for a hearing must be made within ten calendar days of receipt of the notice of the contested action.

B. Federal Appeals

A home health agency or hospice wishing to contest an adverse CMS determination may request a hearing before an Administrative Law Judge of the federal Department of Health and Human Services, as provided in 42 CFR 498.

VII. COMPLAINTS

A. Entity Patient Complaints

The Bureau of Quality Assurance responds to two types of health care complaints: entity practices and caregiver misconduct. The Health Services Section of the Bureau receives complaints and conducts complaint surveys for entity practice concerns such as inappropriate or inadequate health care, lack of entity staff training, understaffing, poor quality care, etc. For complaints concerning home health and hospice agencies, contact the Home Health/Hospice Hotline at 1-800-642-6552. Complaints may also be submitted in writing to Bureau of Quality Assurance, Health Services Section, 2917 International Lane, Suite 300, Madison, WI, 53704.

B. Caregiver Misconduct

Complaints about caregiver misconduct relate to specific incidents between a caregiver and patient such as:

- Abuse--hitting, slapping, verbal, or sexual actions;
- Neglect--intentional carelessness or disregard of policy or care plan; and
- Misappropriation--theft, using property without consent such as telephone or credit cards.

For complaints concerning noncredentialed caregivers, such as nurse aides or personal care workers, contact the Caregiver Intake Unit at (608) 243-2019, or E-mail Caregiver Intake. For complaints concerning credentialed staff (nurses, doctors, LPNs, counselors, etc.) contact the Department of Regulation and Licensing at (608) 266-7482.

All entities regulated by the Bureau of Quality Assurance must investigate all allegations of caregiver misconduct, immediately protect patients from subsequent incidents of caregiver misconduct, and make a determination whether the incident must be reported to BQA. To assist in making those determinations, refer to the Caregiver Misconduct and Injuries of Unknown Source Entity Investigation and Reporting Requirement flowchart. To report allegations, use form DDE-2447, Incident Report of Caregiver Misconduct and Injuries of Unknown Source. The documents are located on the Department of Health

and Family Services Internet at www.dhfs.state.wi.us/caregiver/contacts/Complaints.htm, or contact the Caregiver Central Intake by phone at (608) 243-2019.